PM FORM 8.5.1
MEDICAL CARE EVALUATION (MCE) STUDY
REQUEST FOR REGISTRATION

[NAME OF RBHA OR TRBHA]
(See PM ATTACHMENT 8.5.1 for instructions pertaining to form completion)

NAME OF FACILITY:

AHCCCS PROVIDER ID #:

POPULATION: **SMI** ☐ **GMH/SA** ☐ **CHILDREN** ☐

LEVEL OF FACILITY: **INPATIENT HOSPITAL** ☐ **MENTAL HOSPITAL** ☐
RTC ☐ **SUB-ACUTE HOSPITAL** ☐

MCE STUDY PERIOD: **From:** **To:**

I. TITLE OF STUDY:

II. DESCRIPTION OF STUDY:

III. RATIONALE

1. Discuss the reasons for the selection of the study topic (i.e., underlying problems or concerns that led to the choice of this topic).

2. State the significance (usefulness) of this study. Include references or theoretical framework used in conceptualizing the study topic.

3. Identify the components of quality to be assessed by this evaluation:

☐ accessibility of care	☐ appropriateness of care	☐ continuity of care
☐ effectiveness of care	☐ efficacy of care	☐ efficiency of care
☐ consumer perspective	☐ safety of care environment	☐ timeliness of care

Provider/Facility Approved by (Print Name): Date:

Title: Signature: _____

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RBHA/TRBHA Review:

Will the proposed study serve to identify and analyze medical or administrative factors related to patient care?

Yes ☐ No ☐

Does the proposed MCE study use a sound study methodology?

Yes ☐ No ☐

Is the proposed MCE study approved by the T/RBHA?

Yes ☐ No ☐

Approved by T/RBHA QM/UR Committee:
(List names of committee members)

Date:

Approved by T/RBHA Medical Director:

Date:

No: Additional Information needed: